PARTNERING FOR A NEW LEVEL OF CARE

U.S. Department of Defense

Patient Safety Program

Decision Brief

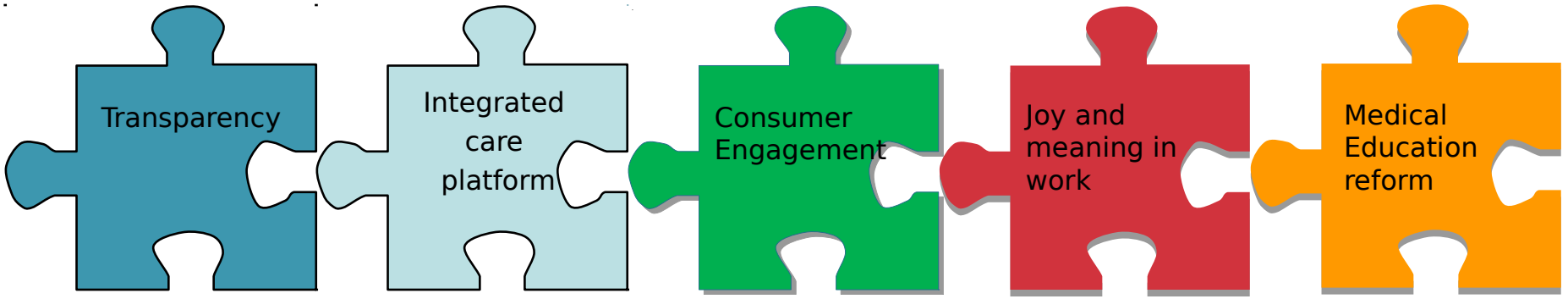
Department of Defense (DoD) Session

Patient Safety Solutions Center

Name
Date

Start With a Vision: Transformation

"We envision a culture that is open, transparent, supportive, and committed to learning; where doctors, nurses, and all health workers treat each other and their patients competently and with respect; where the patient's interest is always paramount; and where patients and families are fully engaged in their care."



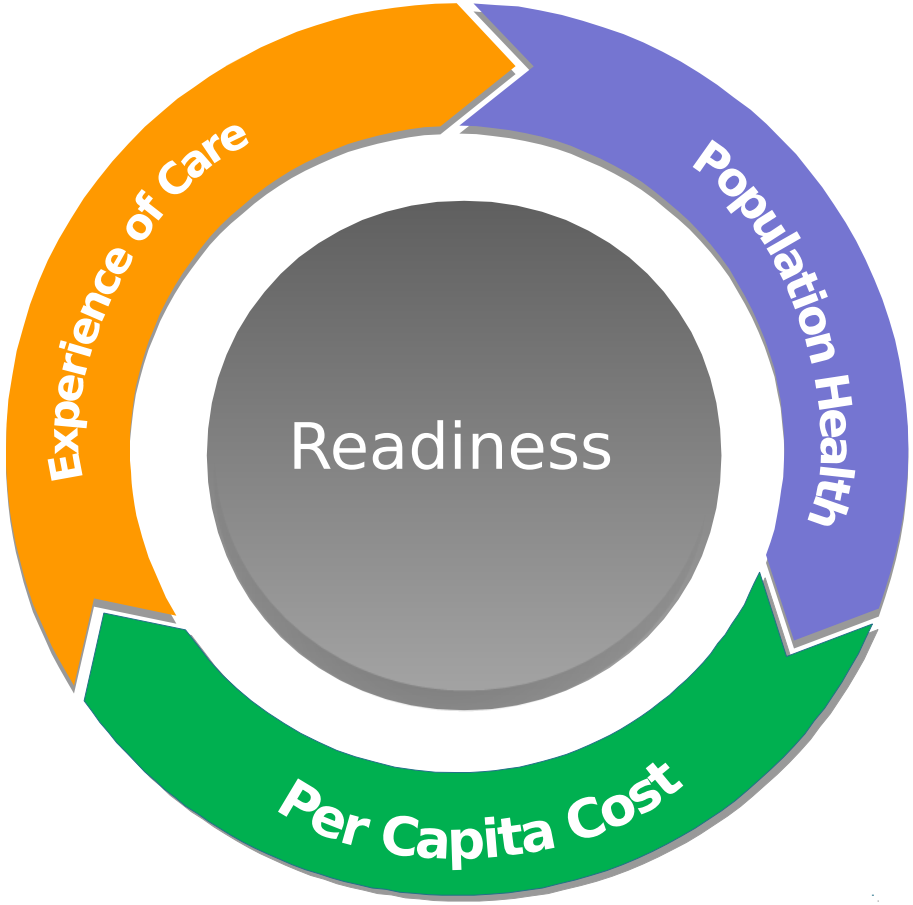
Transformation is an integrated process.

Lucian L. Leape, et al. "Transforming Healthcare: A Safety Imperative." *Quality and Safety in Healthcare* Volume 18, Issue 6 (2009): 424-428

DoD Patient Safety Program fits within the MHS Quadruple Aim

The MHS Quadruple Aim

- Readiness: Enabling a medically ready force, a ready medical force, and resiliency of all MHS personnel.
- Experience of Care: Patient and family centered care that is seamless and integrated. Providing patients the care they need , exactly when and where they need it.
- Population Health: Improving quality and health outcomes for a defined population. Advocating and incentivizing healthy behaviors.
- Per Capita Cost: Managing the cost of providing care for the population. Eliminate waste and reduce unwarranted variation; reward outcomes, not outputs.



MHS Strategic Plan

The MHS published a new strategic plan in summer 2008

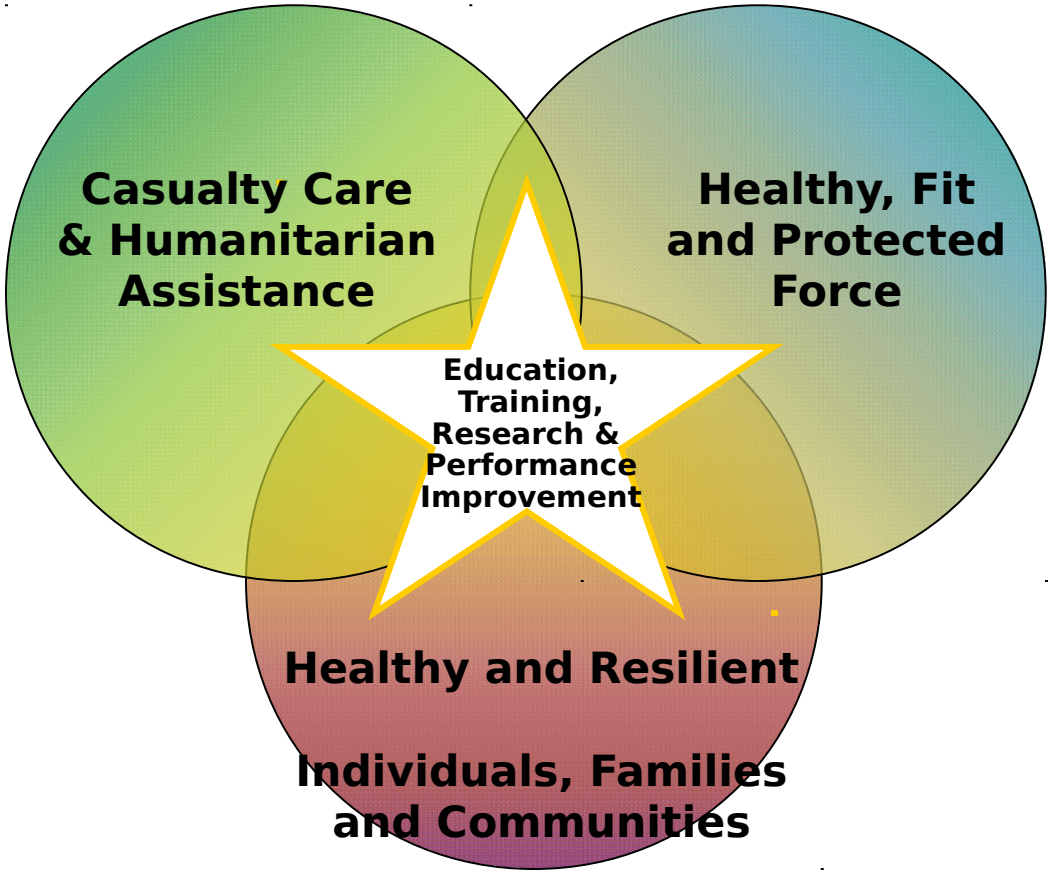
MHS Mission

Our team provides optimal Health Services in support of our nation's military mission—anytime, anywhere.

MHS Vision Statement

- The provider of premier care for our warriors and their families
- An integrated team ready to go in harm's way to meet our nation's challenges at home or abroad
- A leader in health education, training, research and technology
- A bridge to peace through humanitarian support
- A nationally recognized leader in prevention and health promotion

The MHS Four Mission Elements:



Strategic Priorities: Where does Patient Safety fit?

MHS Strategic Priorities 2008-2010

1. Enhance warrior care –
2. Build a bridge to peace –
3. Promote patient choice and accountability –
4. Communicate MHS value, and build an interactive community –
5. Deliver information to people so they can make better decisions -
6. Continuously improve quality and value -
7. Support and develop our people -
8. Strengthen medical education and research
9. Improve governance by aligning authority and accountability

Strategic Priorities

- Promote patient choice and accountability, promote healthy communities and demonstrate MHS commitment to safety and quality outcomes
- Communicate MHS value, and build an interactive community to improve clinical quality, performance and integration

Patient Safety Initiatives

- Deploy a web-based Patient Safety Reporting System (PSR)
- Deploy the AHRQ-developed, web-based Patient Safety Culture Survey to all MHS fixed facilities
- Champion the TeamSTEPPS® Communication Campaign across the MHS direct care system

Note: These are examples; many more exist…

DoD Patient Safety: Moving to a Greater Partnership

Begin Partnerships

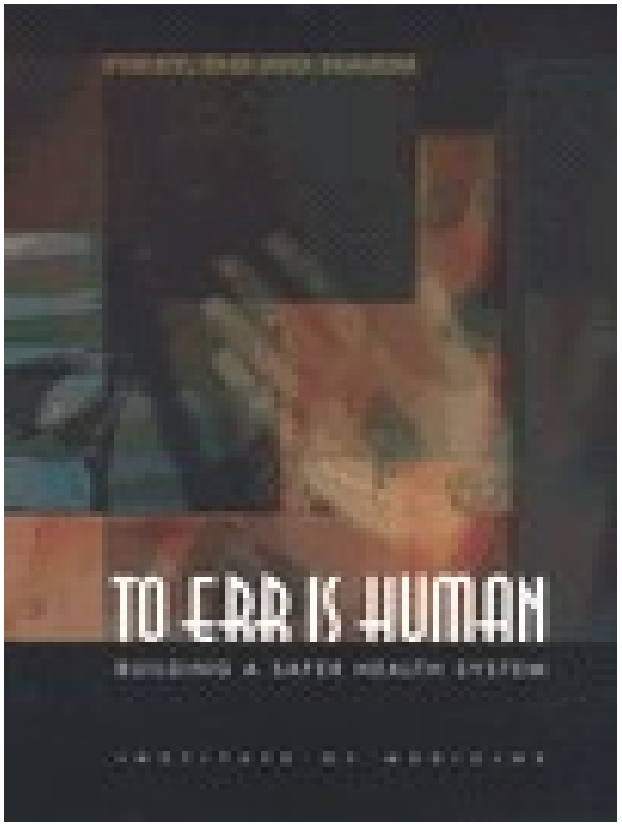
- Enable local patient safety champions (Patient Safety Managers and change teams) to identify, prevent, and address errors to enhance patient safety at the DoD facility level
- Provide centralized resources, activities, and initiatives for local patient safety champions to promote patient safety

Advance Partnerships

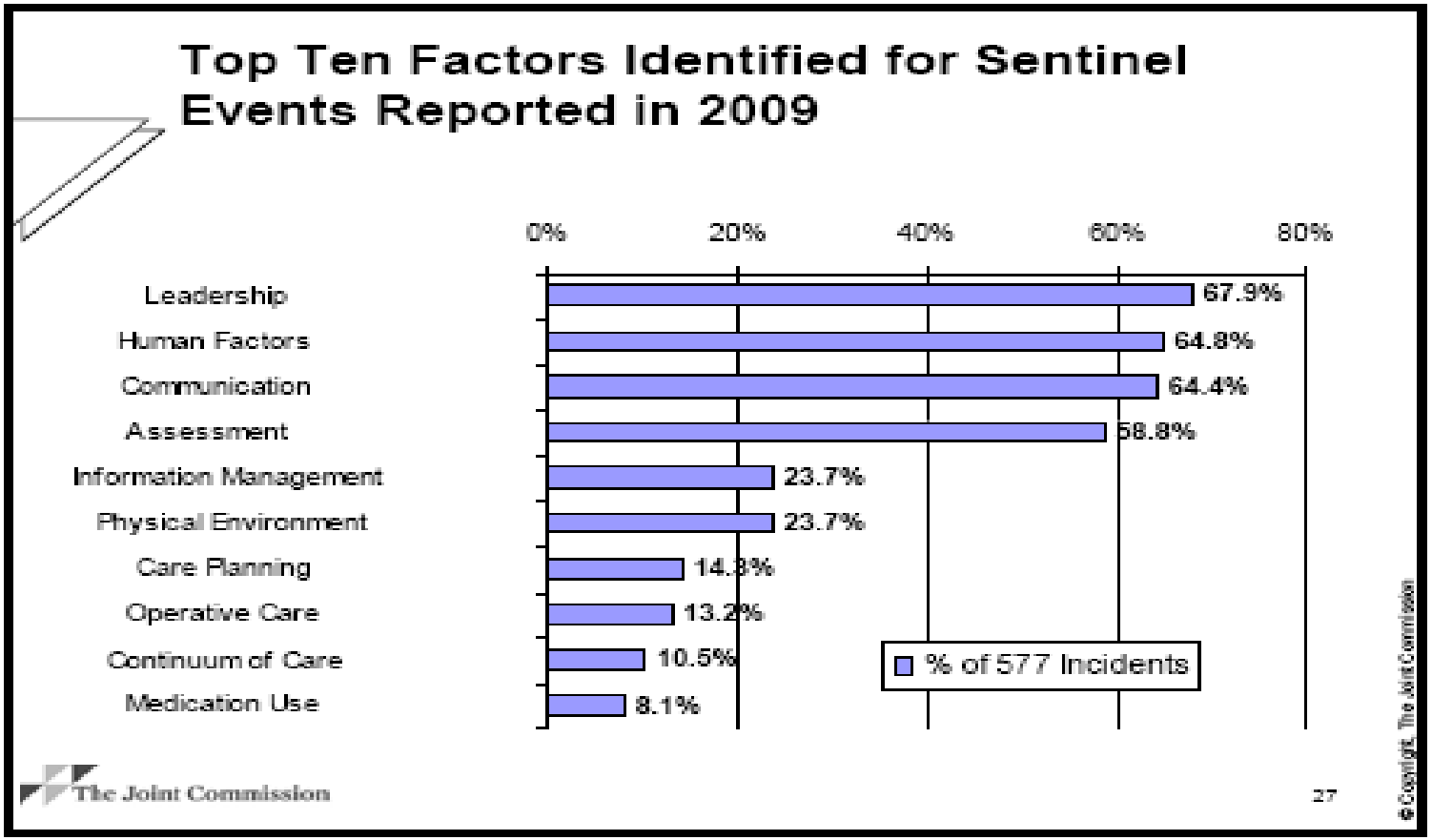
- Create more interactive forums where local champions can quickly learn from one another
- Establish relationships between errors and potential solutions
- Help local champions prioritize patient safety activities/initiatives

The Challenge

- 1999 IOM Report:
  - "…tens of thousands of Americans die each year from errors in their care and hundreds of thousands suffer or barely escape from non-fatal injuries"
  - 44,000-98,000 deaths
  - Million injuries
  - Most preventable



Top Ten for Sentinel Events: The Joint Commission 2009



Why a Teamwork Initiative?

- Approximately 98,000 deaths per year due to preventable medical errors in the US (IOM, 1999)
- **60% of preventable medical errors are a result of communication breakdown**
- Evidence indicates teamwork:
  - Reduces errors/improves outcomes
  - Increases effectiveness and efficiencies
  - Results in increased patient and staff satisfaction

The Goal

- Prevent iatrogenic patient harm
- Transform the MTF into a High Reliability Organization (HRO)
- On par with:
  - Navy Nuclear Power
  - Carrier Flight Deck Operations

MHS Culture of Safety

Patient Safety Culture Area	Overall MHS % Positive		Difference	Change
	2005/ 2006	2008		
1. Teamwork Within Work Areas	75	76	+1	↑
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety	72	73	+1	↑
3. Management Support for Patient Safety	71	73	+2	↑
4. Organizational Learning—Continuous Improvement	68	70	+2	↑
5. Overall Perceptions of Patient Safety	66	67	+1	↑
6. Feedback and Communication About Error	64	64	0	—
7. Frequency of Events Reported	60	63	+3	↑
8. Communication Openness	61	61	0	—
9. Teamwork Across Work Areas	59	60	+1	↑
10. Handoffs and Transitions	47	49	+2	↑
11. Staffing	45	46	+1	↑
12. Nonpunitive Response to Error	44	45	+1	↑

What are YOUR results?

What is TeamSTEPPS?

TeamSTEPPS *Goal:*

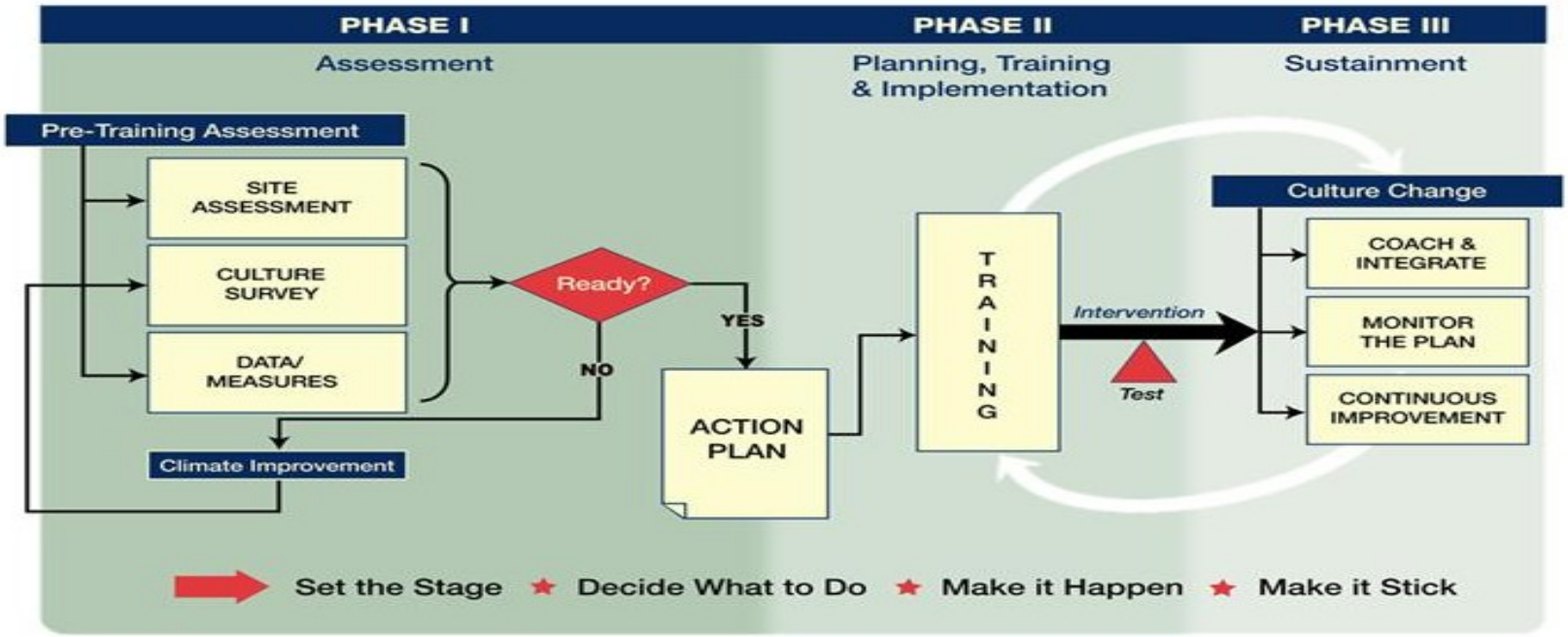
To produce highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for our beneficiaries

TeamSTEPPS is an evidence-based teamwork system aimed at optimizing patient outcomes by **improving communication and other teamwork skills** among healthcare professionals; a powerful solution to improve patient safety.

- Comprehensive suite of training curricula, videos, and resources
- Designed to integrate teamwork principles into practice in healthcare
- Provides practical tools and strategies adaptable to any healthcare setting

TeamSTEPPS Roll-Out

Onsite or Consult (4-6 hours) → **2 months later training sessions** → **Ongoing coaching, consultation, 6 months post**

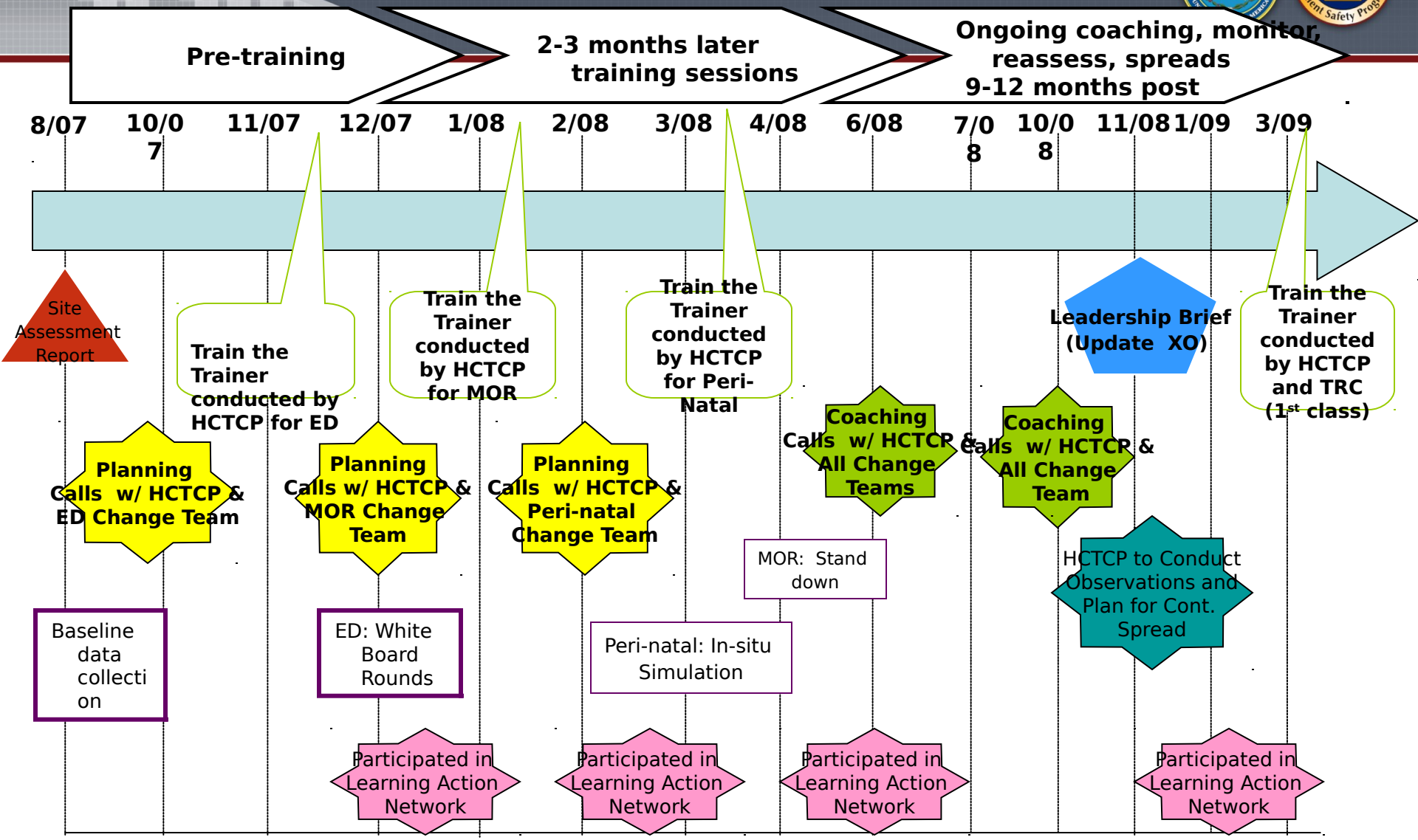


Spread, impact, and sustainability take time and commitment

Roll-Out: Details

- Phase I: Site Assessment: *Set the Stage*
  - 2-3 Days on-site
  - Follow-up report
- Phase II: Planning, Training, Implementation: *Make it Happen*
  - Train the Trainer: 2.5 – 3 days (Includes simulation practice)
  - Train the Participant (Staff): 1 or 4 hours
- Phase III: Sustainment: *Making it Stick*

TeamSTEPPS Initiative Timeline: Potential



*Set the stage *Decide What to do *Make it happen

*Make it stick

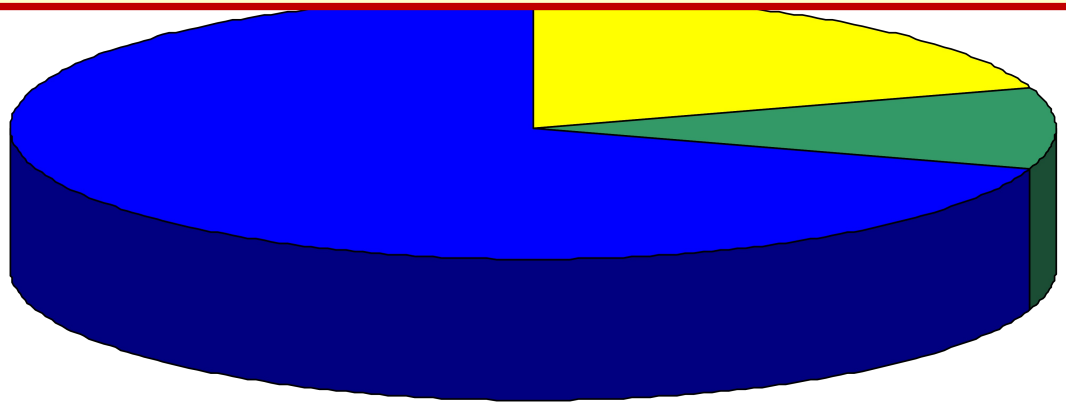
Safety Essentials

- Effective communication
- An environment of “psychological safety”
- Thirst for feedback & output metrics
- Accountability
- Teamwork

Practice to Enhance Learning

Why practice opportunities are critical to achieve successful training transfer

Salas et al. 2009: 20% of variations in team performance due to training quality, 80% to organizational factors



- **Preparation and Readiness: 20%**
- **Learning Intervention: 10%**
- **Application Environment: 70%**

Source: Jim Kirkpatrick, 2006 ASTD Study

Critical Success Factors

Organizational Barriers & Success Factors

Success Factors:

- *Visible* leadership support
- Frontline champions & "coaching"; staff "buy-in"
- Communication campaign
- Integration into normal ops
- On-going measurement *(with feedback to staff)* to monitor and show impact
- Planning
- Training: newcomer, refresher; customized to mission

Challenges:

- Staff turnover & shortages
- Leadership turnover
- Deployments
- Lack of visible leadership support
- Lack of frontline staff support
- Bad actors – no accountability system
- Limited time for training

Training Evaluation Plan

Level 5 – Return on Investment **Was the training worth the cost?**

L
behavior positively affect the organization?

L r
Did the participants change their behavior on-the-job based on what they learned?

Organizational Factors

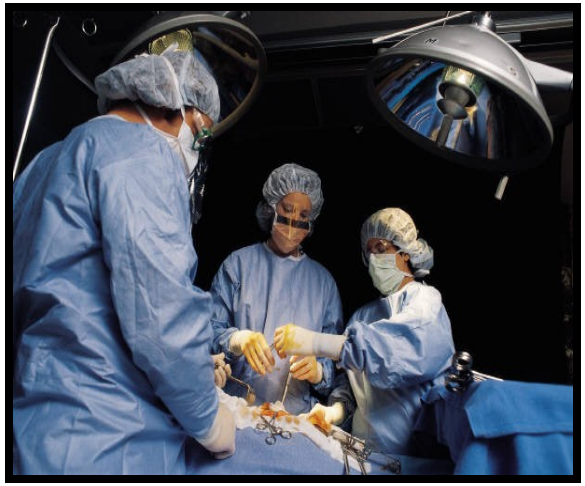
Level 2 – Learning: **What skills, knowledge, or attitudes changed after training? By how much?**

Le
training?
What do they plan to do with what they learned?

Individual Pre-training Experiences & Attitudes

Sample MTF Reports of L4 Outcomes (N = 14)

- Staff have clear direction of plan (white boards)
- Decreased “patient harm” incidence and “patient safety event” reports
- Increased adherence to best practices
- Increased information transfer accuracy
- Glitch capture and correction – knowledge, training, equipment gaps/problems
- Increased staff and patient satisfaction
- Reduced nursing report time
- Improved equipment/staff utilization & efficiency (e.g. decreased OR start/turnover delays)
- Increased patient appointment availability
- Increased efficiency per patient encounter



Roles and Responsibilities: MTF and TMA/PSP

TMA/PSP

- Conduct site assessment and follow-up with report (May do 2-3 visits)
- Determine best training option with NMCSD (on-site, TRCs, eLearning, Tool Kits, etc)
- Customize curriculum for NMCSD
- Conduct or coach Train the Trainer with multidisciplinary staff
- Provide training and sustainment materials (DVDs, Pocket Guides, Cards, Posters, etc.)
- Provide external coaching and consultation
- Provide opportunities to support learning
  - Commander's Forum, Learning Action Networks, Webinars, Collaborative
- Pay travel costs

MTF

- Success Factors
- Identify members of Guiding Coalition and Change Teams
  - All complete the eGuide to Action prior to training
- Participate in site assessment as observes and interviewers
- Prepare and make available data requirements (Culture Survey, satisfaction, etc.)
- Attend training and prepare to "pay it forward"
- Complete Action Plan; Includes:
  - Training, Coaching, Communication, and Evaluation Plans
- Participate in external coaching and consultation calls with TMA
- Develop a mechanism to monitor and collect information on progress of plans
- Provide success stories

Patient Safety Communication Toolbox

http://
health.mil/dodpatientsafety

Public Web site

Secure connection

DOD information sharing forum

Webinars

Newsletters

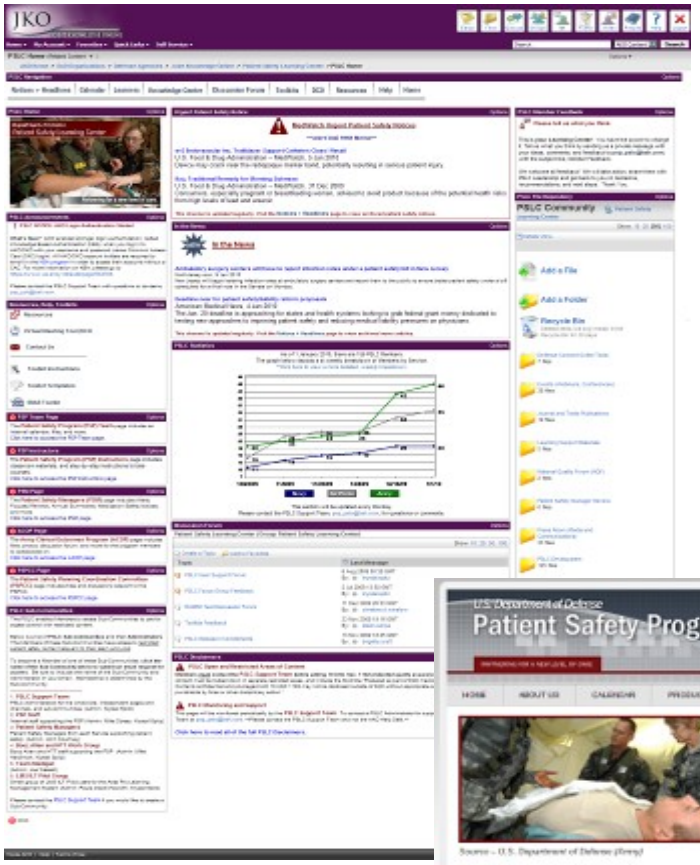
Promotional materials

Event reporting analysis

DoD Patient Safety Learning Center

Share knowledge in a secure online portal for Tri-Service collaboration

- Online discussion forums
- DoD patient safety information
- Lessons learned from RCAs
- Calendar of learning events and activities
- Virtual meeting tools
- Training materials, toolkits, and resources
- Specialty communities



Register for and login at http://health.mil/dodpatientsafety

Back-Up Slides

Aligning with National Quality Forum

Safe Practices, 2009 Update: Creating & Sustaining a Culture of Safety

- Safe Practice 1: Leadership Structures and Systems
- Safe Practice 2: Culture Measurement, Feedback, and Intervention
- Safe Practice 3: Teamwork Training and Skill Building
- Safe Practice 4: Identification and Mitigation of Risks and Hazards

Are we leading the MHS to a culture of safety?

…Focusing on 4 of 34 safe practices

Common Thread?

Actively engaged leadership

- "Inadequate leadership is a contributing factor in over 50% of sentinel events"
  - Joint Commission, 2006

What Can TeamSTEPPS Do for Us?

Emergency Department[1]

After implementation of multiple medical team training programs:

- Improved observed team behaviors.
- Enhanced staff attitudes toward teamwork.
- Reduced observed clinical errors.

Clinical Units in a Medical Center[2]

After implementation of SBAR to improve communication among clinical caregivers:

- Reduced rate of adverse drug events (from 30 to 18 per 1,000 patient days).
- Improved medication reconciliation at patient admission from 72% to 88% and at discharge from 53% to 89%.

1. Morey, JC, Simon, R, Jay GD, et al. Error reduction and performance improvement in the emergency department through formal teamwork training: Evaluation results of the MedTeams project. Health Serv Res. 37:1553-1581, 2002
2. Haig, K., Sutton S, Whittington, J. SBAR: A shared mental model for improving communication between clinicians. JL Comm J Qual Patient Saf 32(3):167-75, March 2006.

What Can TeamSTEPPS Do for Us?

Labor and Delivery Units[1]

After implementation of multiple teamwork strategies and tools:

- A 50% reduction in the Weighted Adverse Outcome Score (WAOS). The WAOS describes the adverse event score per delivery.
- A 50% decrease in the Severity Index, which measures the average severity of each delivery with an adverse event.

Intensive Care Units (ICU)[2]

After implementation of a "Patient Daily Goals" form to facilitate staff communication:

- A 50% decrease in mean ICU length of stay from 2.2 days to 1.1 days.

1. Mann, S, Marcus, R, Sachs, B. Lessons from the cockpit: How team training can reduce errors on L&D (Grand Rounds) Contemporary OB/Gyn v51 i1:34(8), January 2006.
2. Pronovost, P, Berenholtz, S, Dorman, T, Lipsett, PA., Simmonds, T, Haraden, C. Improving communication in the ICU using daily goals. J Cri Care 18(2):71-5, Jun 2003.

What Can TeamSTEPPS Do for Us?

Operating Rooms (OR)

After implementation of a "pre-op" brief:

- Increased OR communication.[1,2]
- Increased administration of properly timed prophylactic antibiotics prior to incision from 84% to 95%.[1]
- Increased pre-op deep vein thrombosis prophylaxis prior to induction from
  92% to 100%.[1]
- Error avoidance: Pre-op brief revealed seven patients (3.3%) with previously unidentified severe surgical risks — surgery cancelled.[1]
- A 16% reduction in nursing turnover rate.[2]
- A 19% increase in OR employee satisfaction.[2]

1. Awad, SS, Fagan, SP, Bellows, C., Albo, D, et al. Bridging the communication gap in the operating room with medical team training. Am J Surg 190(5): 770-4, Nov 2005.
2. Leonard, M,, Graham, S, Bonacum, D. The human factor: The critical importance of effective teamwork and communication in providing safe care. Qual Saf Health Care 13 Suppl 1:i85-90, Oct 2004.